Questions for the Record
Honorable Steve Buyer, Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
May 7, 2003

Hearing on VA's Progress on Third Party Collections

Question 1: In Karen Sagar's (the MCCF Director at the Martinsburg WV VAMC) testimony before the Subcommittee on September 21, 2001, she stated that her section, the Business Programs and Operations Service, had 8 FTEE in the Coding/Billing Unit. Does the Chief Business Office include the cost of coders' salaries and training in its "cost to collect?" If not, why not?

Response: Consistent with health care industry standards, the "cost to collect" metric, which is calculated by dividing operational costs by total collections, does not include salaries of medical records coding staff.

Question 2: In VA's testimony, the figure $2.1 billion is used for the amount VA expects to collect in FY 2004. Is this based upon the current copayment rate?

Response: No. The figure of $2.1 billion includes all the recommended policy changes as presented in the President's FY 2004 Budget Submission.

Question 3: According to the GAO, VA has completed 10 of the 24 detailed recommendations in its Revenue Cycle Improvement Plan of 2001. When will the VA complete the remaining 14 recommendations? Are they being incorporated into a new plan?

Response: VA is continuing to pursue the objectives of the 2001 Revenue Improvement Plan. Of the original 24 Action Items, 14 are fully completed; one was deemed cost ineffective and cancelled; and nine are on target for completion.

With the establishment of the VHA CBO, an expanded revenue action plan has been formulated that combines the 2001 Revenue Improvement Plan with a series of industry proven tactical and strategic objectives, including establishment of industry based performance and operational metrics, development of technology enhancements and integration of industry proven business approaches including the establishment of consolidated patient account centers. Attachment A provides further information on the 2001 Revenue Improvement Plan and the expanded revenue action plan.

4. When VA fails, upon an initial attempt, to collect an adequate payment from insurance companies what additional follow-up steps does it take? In general, how successful are follow-up attempts?

Response: To collect from an insurance carrier, facilities have a number of tools that they employ for follow-up including: letters, telephone calls and use of contract staff both on and off site. Additionally, accounts receivable staff work closely with utilization review staff on writing appeals based on medical denials. Success in follow-up attempts is judged by the VHA's performance metric for percentage of accounts receivable days over 90 days delinquent. VA tracks these performance metrics on a facility level and they are posted to the Chief Business Office website and presented to the VA's Business Oversight Board chaired by the Secretary. For the third quarter of FY2003, VA's overall percentage of accounts receivable greater than 90 days was 41.8%, which is well ahead of the targeted goal of 55% at the end of this time period.

Question 5: In testimony it states that VA has implemented electronic claims generation. Where is this being done? What benefits have been derived from this? How much has this reduced the processing time?

Response: The transition to total electronic claims generation is underway at all VA facilities. The percentage of electronic bills is increasing as additional insurers are being brought on board electronically, notably certain Blue Cross Blue Shield plans. Furthermore, at present, most health plans do not accept electronic secondary claims. When HIPAA electronic transactions standards go into effect on October 16, 2003, we expect a greatly expanded number of health plans to accept secondary claims electronically. Data from one of VHA's first sites to install electronic billing do provide preliminary evidence of the benefits of electronic billing. Time from the issuing of bills to receipt of payment has moved from an estimated average, before electronic billing, of 30-45 days to a current estimated average of 7-14 days. At this site, biller productivity has risen 42% since electronic billing software came into use.

Question 6: How did VA determine that 20-25% of enrolled veterans have additional health insurance?

Response: The estimated percentage is based on a 2002 VHA Survey of Veteran Enrollees. According to the survey, 78% of veterans enrolled in the VA health care system have some type of public or private health care coverage, including 56% who have some type of Medicare coverage (not billable by VA) and 12% who are in HMO plans, many of which limit or exclude out-of-network payments. Additionally, data indicate that 13% of the enrolled veterans have billable insurance through Fee for Service Plans and 28% percent through Medigap plans.

Question 7: What is VA's level of confidence in the accuracy of the numbers on which it bases its cost to collect?

Response: As discussed in the response to Question 1, the current cost to collect data is generally reliable but not without vulnerability because of operational costing variability and Medicare adjustment factors.

Question 8: In its April 2003 CAP review of the VA Roseburg Health Care System in Oregon, the Inspector General's Office identified 10,393 insurance accounts receivable with a total value of $1.9 million. Of these, 8,679 insurance accounts were older than 90 days with a value of $1.3 million. The IG, in consultation with MCCF supervisor, estimated that if the MCCF staff more aggressively pursued these claims they could increase the amount collected by 5%, or $65,000. Does the Chief Business Office agree with these numbers? Why weren't claims contracted out, per Dr. Roswell's directive from last year?

Response: The Chief Business Office has contacted the medical center and spoken with the Supervisor referenced in the CAP report for Roseburg. To this individual, the figure of 5% referenced represented an overall perspective on how much an aggressive AR program could bring annually in terms of additional revenue. Relative to the specific claims over 90 days ($1.3 million) referenced in the CAP report, we believe based on a facility's typical distribution and collections for non-medigap and medigap receivables, the collection potential to be $520,000 for this set of receivables, or 40% of the $1.3 million. This assessment is based on national trends and standards.

In the directive from Dr. Roswell, facilities were given the option of not contracting out if they were able to provide demonstrated evidence of a better in-house program. At the time of the memo from Dr. Roswell in May of 2002, Roseburg provided evidence to that effect to the Network. However, subsequent staffing shortages caused a backlog. The CAP report indicates that the staffing plan presented by the facility was acceptable and the issue considered resolved.

9. Why doesn't VA separate Medigap collections from other insurance collections? If they were separated, would that give both VA and Congress a truer picture of the Chief Business Office's successes and efficiencies?

Response: Existing VA data systems do not currently accommodate a stratification of third party receivables that enable separation of Medigap and non-Medigap bills. However, effective November 2003, with the implementation of the Medicare Remittance Advice capability, VA will be able to do so.

Question 10: How can VA assure Congress that it will finally reach an agreement with CMS on the Medicare Remittance Advice issue this November?

Response: VHA is working closely with CMS and Trailblazer Health Enterprises, a CMS-contracted Medicare Fiscal Intermediary and Carrier, to have an electronic MRA process in place in November 2003. We are now in the process of conducting user acceptance testing, which is a final step in the development process. As a result, we do not anticipate any delays in completing this project in November.

Question 11: How can the discrepancy between the collections staff salary numbers provided by the Chief Business Office and the Office of Policy and Planning be described?

Response: The Chief Business Office (CBO) and the Office of Policy and Planning (OPP) use the same data source to gather information on both the number and salaries of collection staff. However, discrepancies can occur if each office submits responses reflecting numbers of positions and salaries at differing points in time. To illustrate, on February 10, 2003, the Office of Policy and Planning reported that as of March 31, 2002, the MCCF total positions were 2,295 with salaries including full-time and part-time at $79,788,986. As of March 31, 2003, MCCF total positions were 2,826 with salaries, including full-time and part-time at $101,259,819. Thus, between March 31, 2002, and March 31, 2003, there was an increase of 531 total positions.

To avoid reporting discrepancies in the future, both the CBO and OPP will work more closely together to ensure that the information provided is clearly defined.

Question 12: What steps is the VA taking to ensure full utilization of electronic medical records by October 1, 2003?

Response: The utilization of the electronic record is being monitored through an existing monitor of clinician order entry, and beginning in FY 2004 an additional monitor of electronic notes per each encounter will be added. The performance monitor on order entry by clinicians has shown a steady increase in compliance with an overall rate of 91%. A new monitor on progress notes associated with a clinic visit will be released in the fall of 2003.

Question 13: Will the VA be HIPAA compliant by November 2003? How long will HIPAA implementation take?

Response: VHA is already complying with the Privacy Rule of HIPAA and expects to be compliant with the Electronic Transactions and Code Sets Rule by the October 2003 deadline. VHA will continue to assess and modify its business functions as needed to accommodate the requirements of the Security Rule by the April 2005 deadline.

Question 14: Please rank order facilities from most efficient to least efficient in collections. Please also provide this list in net collections?

Response: VA establishes collection goals for each facility and uses them to measure the facilities' level of effectiveness. We have included the ranking of each VHA facility by their percentage collection to goal, using both Medicare adjusted and unadjusted figures. We monitor them using targets and a color-coding scale as described in our answer to question 17. (See Attachment B.)

Question 15: What type of action is being taken to ensure that all health care providers accurately document every treatment encounter and associated tests and procedures with required diagnostic information?

Response: The Clinical Indicator Project, Iteration #1, will be released to the field in November 2003. This project will require the clinician to associate a diagnosis for each ancillary service, medication, or prosthetic item ordered. Electronic encounter forms are being used to assist with correct coding of diagnoses and procedures, and available local and national documentation templates prompt clinicians for needed documentation.

Question 16: When is the VA planning for the activation of a National Revenue Call Center?

Response: The VA Health Revenue Center (HRC) in Topeka, KS, anticipates implementing a Revenue First Party Call Center early FY 2004 with incremental rollout beginning in FY 2005. Implementation will be in three phases:

> Phase I – Through direct access to each data base from the initial three VISN's, HRC will initially provide services by handling telephone inquiries from veterans regarding billing questions and concerns. All adjustments/inputs to veterans' account will be performed by the medical center staff.
>
> Phase II – Contingent upon development of an interface to allow seamless access to medical center data bases, first party call center services will be incrementally rolled out to additional VISN's during FY 2005.
>
> Phase III – Call agent responsibilities, to include increase or decrease adjustments, minor editing and other revenue-related services will be progressively added to the services provided by the call center.

Question 17: How do the performance standards implemented at the beginning of FY 03 measure amount of collections, gross days revenue outstanding, days to bill, etc? Do they set a minimum? A desirable range? A benchmark? A target?

Response: The Business Oversight Board (BOB) chaired by Secretary Principi and the Deputy Secretary have established a number of industry-derived performance metrics. While no minimum values have been set for the metrics, quarterly and end of year targets have been established using private industry benchmarks from HARA, the Hospital Accounts Receivable Analysis journal. Further, all Veterans Integrated Service Network (VISN) and facility directors have these standards in their performance contracts and are judged against standards set for fully successful and exceptional performance.

The metric results are rated according to a three-color scale. A VISN/facility that achieves 90% or better of its target receives a green rating. One that achieves between 70% and 89.9% of its target receives a yellow rating. And a VISN/facility that achieves less that or equal to 69.9% of its target receives a red rating. Below is a table containing the metrics, their respective HARA benchmarks, and the targets set by VHA.

	Business Oversight Board Metrics FY03			
	Collections	GDRO	Days to Bill	AR > 90 Days
HARA Benchmarks:	N/A	57 Days	9.4 Days	26.1%
Quarter 1	$356,202M	225 Days	100 Days	84.0%
Quarter 2	$746,461M	185 Days	80 Days	70.0%
Quarter 3	$1,160,721M	150 Days	65 Days	55.0%
Quarter 4	$1,575,260M	100 Days	50 Days	45.0%

Question 18: Has VA identified a system or software solution that would identify all health plans in which a veteran is enrolled?

Response: At this time, no commercial product has been identified that would provide the VA with health insurance coverage information for its entire veteran population. VA is collecting insurance eligibility responses gained through the use of HIPAA-mandated eligibility transactions and will re-use this information within the Veterans Health Administration network. This, combined with the electronic sharing of manually identified insurance, will provide an ever-growing source of third-party health insurance information, which will, in turn, support the third-party insurance billing activity. We note further that the company testifying at the May 7 hearing claiming expanded insurance verification capabilities has no installations of their system to support their claim. Further, we are concerned whether their product complies with HIPAA Privacy requirements.

Question 19: A January 2003 GAO report stated, "VA lacks a reliable estimate of uncollected dollars, and therefore does not have the basis to assess its system-wide operational effectiveness." When will the VA formulate a reliable estimate? Does VA have a methodology which can produce a reliable estimate? Explain.

Response: The GAO statement is in part accurate. Due to a combination of accounting system limitations, data and reporting deficiencies, and statutory requirements prohibiting collection from Medicare, VA does not have a totally reliable method of identifying uncollected dollars. We have, however, developed reasonably reliable methods of estimating uncollected dollars, explained as follows.

The total value for third party accounts receivable is estimated at $2.1 billion through June 2003. Thirty percent of this total is attributable to veterans with fully paying health insurance policies. Seventy percent of the total is attributable to Medicare-eligible veterans, who also have Medigap policy coverage. Since VA cannot collect from Medicare, the collection potential for this population is estimated at approximately 20% of the total accounts receivable. This 20% comes from the Medigap policies. The breakdowns are as follows:

Third Party Accounts Receivable as of June 2003

30% attributed to "fully paying policies"	$ 633,584,650
70% attributed to "Medigap policy coverage"	$1,478, 364,184
Total A/R	**$2,111,948,834**

Total Collection Potential

fully paying policies (30% of total A/R)	$ 633,584,650
Medigap policy coverage (20% of total A/R)	$ 295,672,837
TOTAL COLLECTION POTENTIAL	**$ 929,257,487**

Implementation of the new Patient Financial Services System (PFSS) and related developmental efforts (Medicare Remittance Advice project) will include reporting capabilities that dramatically improve our ability for producing such data.

Question 20: In September 2001, former Under Secretary of Health Thomas Garthwaite testified that collections from the medication co-payment increase were projected to increase by $225 million in FY 2002 and $300 million in FY 2003. Did the VA meet these projections? Why or why not?

Response: The projections for FY 2002 were actually exceeded. Medication copay collections were $139 million in FY 2001 and $377 million in FY 2002, representing a $238 million increase over FY 2001. The FY 2003 projected medication copay is $651 million, a $274 million increase over FY 2002 and $512 million over FY 2001.

Question 21: The GAO reported in January 2003 that "the VA has established the Chief Business Office in VHA to direct VHA's Revenue Office and to develop a new approach for VA's collections activity." How has it been involved with MCCF reform? Please provide examples?

Response: Please see Attachment A for a list of activities in this regard.

Question 22: What initiatives beyond the improvement plan has the Chief Business Office developed and/or executed?

Response: See response to Question 3 and Attachment A, outlining the progress on the initiatives in the Revenue Improvement Plan and the new initiatives in the Revenue Action Plan.

Question 23: How much does it cost to run the Chief Business Office? What future funding has been proposed?

Response: The total funding in FY 2003 for the VACO CBO is approximately $24 million. Funding for field activities includes $335 million for the Health Administration Center in Denver, a large portion of which is for CHAMPVA; $20 million for the Health Revenue Center in Topeka; and $6 million for Health Eligibility Center in Atlanta. An increase of approximately $24 million is projected in FY 2004 for impending initiatives.

Question 24: Has the Chief Business Office developed performance measures? Please provide the Subcommittee with a complete list of successful performance measures developed by the Chief Business Office.

Response: Effective FY 2003, VHA, through the CBO, implemented industry-based performance metrics and reporting capabilities to identify and compare overall VA revenue performance. Metrics were implemented to measure revenue program performance including collections, gross days revenue outstanding (GDRO), days to bill, and AR > 90 days. For both VISN and Medical Center Directors the metrics and associated performance targets were incorporated in annual performance contracts effective FY 2003. Additional metrics associated with bills, percentage of collections to bills and cost to collect are also being reported for operational analysis purposes. As analysis and information systems enhancements occur, it is expected that the metrics will be refined and expanded over time. Further, at the end of the current fiscal year, an analysis of the success or lack thereof of each performance metric will determine whether the metric will be incorporated into FY 2004 performance contracts.

Question 25: Once the VA collects third-party funds, who gets to keep the money? The facility or the VISN? If this is not a uniform policy throughout the VA, please explain.

Response: Public Law 105-33 established the Medical Care Collection Fund, and Public Law 105-65 authorized the transfer of collections in the fund to the Medical Care Appropriation where they remain available until expended. Public Law 106-117 signed November 30, 1999, directed that collection funds be returned to the collecting facility.

Question 26: The GAO testified in 2001 about the vital importance of measuring net revenues to determine effectiveness of the program. What is the VA's cost to collect third-party revenues? After the cost of collections has been determined, what is the actual "net" amount kept? The West Palm VAMC collected $18 million last year- what was the net amount?

Response: VA computes the cost to collect by identifying the obligation amounts for each facility for revenue collection activities. This includes, but is not limited to, FTEE, travel, and contractual services. VA does not normally calculate the cost to collect third-party revenues nor the actual "net amount" kept. However, in the last year, West Palm Beach Medical Center collected $18 million. The amount of obligations for revenue collection activities was $1,138,413. Thus, the "net amount" would be approximately $16.86 million.

Question 27: The GAO testified that the VA indicated in August 2002 that 20 hospitals were still working on a step required to transmit bills to all payers. How many hospitals are still working on electronic billing and how many have full functioning electronic billing?

Response: Electronic claims are generated from all VHA facilities through a contracted clearinghouse (WebMD) for transmittal to health insurance companies. WebMD, in turn, submits electronically to those payers who accept electronic claims. If the payer cannot accept claims electronically, WebMD forwards a paper claim. All VHA facilities have implemented electronic claims for those plans that are electronically reachable through WebMD, with additional qualifiers with regard to the Blues Plans. Currently the Blue Cross Blue Shield plans as a group have more idiosyncratic or non-standard electronic billing requirements than most commercial health plans. Further, most health plans do not currently accept electronic secondary claims. When HIPAA electronic transactions standards go into effect on October 16, 2003, successful submission of electronic claims to individual Blue plans should become attainable; likewise, an expanded number of payers is expected to accept electronic submission of secondary claims. Today, all but ten VHA facilities are either successfully electronically submitting claims to their respective Blues Plan or are actively testing these transactions.

Question 28: On page 212 of the IG Audit of VA consolidated financial statements for FY 2002 and 2001, it cites a memo sent by Under Secretary Roswell to all VHA facilities directing them to contract out all aged accounts receivables over 60 days old

to a collection agency. This memo further directs that all facilities report back on actions being taken to implement the directive to the network chief financial officer within 60 days old to a collection agency. This memo further directs that all facilities report back on actions being taken to implement the directive to the network chief financial officer within 60 days. Has this been carried out? How many facilities have complied? For the record, please list facilities that have not complied and why not. How much revenue has this action generated?

Response: All networks have provided status on contracting out at 60 days in response to the May 2002 memorandum from Dr. Roswell. A list of facilities which have and have not complied with contracting out accounts receivable greater than 60 days is provided in Attachment C.

There are presently a number of contractors working on accounts receivable follow-up within VHA. Many VA facilities have a contract with Transworld Incorporated (TSI), which receives a flat rate per follow-up letter ($4.75), sent at varying intervals from the date the account is established. The majority of other contracts are based on a percentage paid to the vendor of the amount collected. In general, the older an account is from the date the bill is established, the greater the percentage of recovery paid to the vendor. The variety of contracts and terms varies considerably by facility and network, and VA is presently in the process of developing a methodology to track recoveries nationally. However, initial survey results indicate that in the most recently completed fiscal year, VA invested $4.5 million for specific accounts receivable collection vendors and collected $60 million.

Question 29: Why isn't the pre-registration of patients carried out at every facility?

Response: It is mandatory for all medical centers to use the pre-registration software and all associated processes. In March 2002, VHA issued a policy directive (2002-015) which re-emphasized the mandated use of the pre-registration and associated processes and procedures currently installed on the Veterans Health Information Systems and Technology Architecture (VistA) at Department of Veterans Affairs (VA) medical centers and Veterans Integrated Service Network (VISN) offices.

In an effort to ensure that each facility complies with this directive, VHA has required that all facilities centralize pre-registration at the VISN level by October 31, 2003. To facilitate this transition, VHA has created a Business Implementation Manager group to ensure consistency in process and procedure. The Chief Business Office has also created a response team to update existing policy and to issue revised instructions and guidance to the field on using pre-registration functionality.

Question 30: One initiative to improve collections laid out in VA's budget request for both 2003 and 2004 was the implementation of a new business plan to reconfigure the revenue collection program that includes both franchise (in-house) and contract

models. In the 2003 budget VA said, "it has made considerable progress in terms of executing the plan." The completion date for the entire project was December 2002. In its FY 2004 submission the same "new business plan" was presented with a new completion date of March 2003. Has this new business plan been fully implemented? Why did it take so long to get this project up and running? How does VA define "considerable progress?"

Response: The final report for this project was delivered in July 2003 and is currently under review. Therefore, full implementation of the plan cannot be asserted until the findings and recommendations are reviewed and evaluated. The delays associated with the startup of this project are attributed to negotiations with labor organizations and space and construction startup activities needed to house re-configured consolidated units. As indicated in the Interim Report, because of these delays, the evaluation portion of the project was extended in order to allow for a full twelve-month period of assessment.

Questions for the Record
Representative Boozman, Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
May 7, 2003

Hearing on VA's Progress on Third Party Collections

Question 1: Would it be beneficial to certify coders and increase their salary? In your opinion, will this help eliminate error and promote effective and efficient coding by the VA?

Response: Yes, it would be beneficial to Veterans Health Administration (VHA) to hire more credentialed coders and to recognize the skills required to obtain credentials with higher compensation. Requiring VA medical centers to employ only credentialed coders would improve coding proficiency and help reduce coding error. This position is supported by numerous audit recommendations from within and external to VA (PriceWaterhouseCoopers, United Audit Systems Inc., and Rainbow Technology/First Consulting Group, and the OIG).

Accurate coding requires training and education in order to understand and apply coding guidelines and criteria. Since the billing and insurance process is intricately tied to coding and abstracting healthcare data, credentialed staff are the industry standard in the private sector and compensation is commensurate with credentials. In the VA, this is not the case. The average annual salary for credentialed coders in VA as of January 2002 was $36,500, while private sector salaries for credentialed coders ranged from $40,000 to $47,500. Current Office of Personnel Management classification standards do not recognize credentials, and that makes it impossible to formally require credentials and remunerate accordingly. To help alleviate this situation, VA has developed a legislative proposal that would enhance the Department's flexibility in hiring credentialed coders (Medical Records Technicians). This proposal is under consideration within the Administration.

VA has also published guidance to field facilities on recruitment and retention avenues available and provided examples of selection and quality factors that can be used to recruit credentialed staff. VA has also initiated a variety of on a local and national level to address the shortage of skilled coders. These include the following:

- establishment of Upward Mobility training programs to train existing staff;
- development of liaisons with educational institutions who provide coding programs;
- recruitment of coders in geographic areas with available coders to help those with critical shortages;

- training and support of current coding staff through education (satellites, web-based learning) and in-house assistance (VHA Coding Council and website inventory of issues and guidance;
- attention to life-style and employee satisfaction such as flexible tours and allowing coders to work from home;
- requiring the use of encoders and claims analyzers to assist with quality coding and submission of clean bills;
- distribution of the recommended scope of work of coders and expected accuracy and production standards;
- requiring the use of electronic encounter forms as of October 1, 2003, to assist clinicians with correct code selection; and
- establishment of a task group to improve recruitment efforts to include advertising campaigns, mail-outs, and presence at job fairs.

Shortage of coders is not just a VA issue. The American Academy of Professional Coders reports that 18% of all medical coding positions are vacant; that 10,000 new positions will be created each year; and that job prospects for formally trained coders will increase 36 percent or more through 2010. The Department of Labor attributes the greater demand on increased scrutiny by third party payors, regulators, courts and consumers. The VHA Fiscal Year 2003-2007 Workforce Succession Strategic Plan identifies certified medical record technicians as one of the top ten mission critical occupations.

Attachment A – Response to Buyer Question 3

The following objectives have been established to complement the improvement actions contained in the 2001 Revenue Improvement Plan. While some of the targeted improvements originated in Revenue Improvement Plan, others are new. All objectives are now classified as immediate (six to 12 months from CBO inception), mid-term (12 to 18 months out) and long-term (18 months and beyond).

Immediate Improvement Strategies: 6-12 months

The following are targeted for implementation between July 2002 and June 2003. Several of the initiatives have been achieved.

Performance Metrics – (Completed/On going) Effective FY 2003, the CBO implemented industry based performance metrics and reporting capabilities to identify and compare overall VA revenue performance. Metrics were implemented to measure revenue program performance including collections, gross days revenue outstanding (GDRO), days to bill, and AR > 90 days. For both VISN and Medical Center Directors the metrics and associated performance targets were incorporated in annual performance contracts effective FY 2003. Additional metrics associated with bills, percentage of collections to bills and cost to collect are also being reported for operational analysis purposes. As analysis and information systems enhancements occur it is expected that the metrics will be refined, improved and expanded over time.

Accounts Receivable Follow-up – (Completed/On going) Outsourcing of accounts receivable follow-up was originally identified as Action Item 20 in the Revenue Improvement Plan. In May 2002, the Under Secretary for Health (USH) issued a memo directing referral of outstanding accounts receivable > 60 days to AR contract entities. (Previously, facilities outsourced receivables > 90 days.) The USH recognized that reduced referral time would result in faster reimbursement while allowing staff to focus on other revenue related activities. As a result, the outstanding AR balance has decreased, despite an increase in the number of bills generated.

Expanded Available Contract Support –(Completed/On going) As proposed in Revenue Improvement Plan Action Item 20, VA established several national and local contracts for outsourcing collections on past-due accounts and insurance collections, as well as services for insurance identification and verification and coding. Currently there are in excess of 70 various contract vehicles available for use within VA. VISNs and Medical Centers have been encouraged to utilize these contracts whenever necessary to improve revenue performance.

Health Revenue Center – In an effort to leverage the skills and capabilities of the former Shared Services Center, in Topeka, KS, the CBO upon inheriting the

operation (June 2002) established the Health Revenue Center (HRC) to pilot regionalization of centralized revenue support activities. To date, HRC efforts have generated an additional $6M in collections attributed to the following initiatives:

- Pre-registration Pilot- (Completed/On Going) The HRC is providing centralized pre-registration services for VISN 11. As of the end of March 2003, the HRC made over 246,000 pre-registration calls to scheduled patients to verify their demographic and insurance information. Between May 2002 and February 2003, the HRC identified over 23,000 new insurance policies, resulting in an additional $4.5M in collections.

- AR Management Pilot – (Completed/On Going) The HRC is providing AR follow-up services for VISN 15 for aged accounts receivable. Contract representatives were engaged to train HRC personnel on proper AR management modeling private sector best practices. Between November 2002 and February 2003, the HRC processed 23,000 cases, of which 16,000 were closed as uncollectable and 7,000 were collected for a total of $1.2M.

- Hartford/USAA Settlement - (Completed/On Going) The HRC has been designated as the national processing center for refund claims related to the settlement between VA and Hartford/USAA insurance companies. Under this settlement, the two companies have paid VA a total of $11.2M (placed in an escrow account at the HRC) to settle claims for care rendered to their veteran policyholders between January 1, 1995 and December 31, 2001. The agreement requires that funds first be utilized to refund payments made by veteran policyholders for first party debt prior to being used by VA for any other purpose, and that each veteran make a claim in writing within one year to the VA for refund. A major communication effort was undertaken to ensure veterans were aware of the potential refunds.

Expedited Development of Electronic Data Interchange – Development of Electronic Data Interchange (EDI) for Insurance Claims (hospital and physician services) has been expedited to position VHA to meet HIPAA deadlines (October 2003). Initial e-Claims software is operational at all VA facilities, and over five million electronic claims have been generated as of June 2003. This software has reduced payment receipt times from those health plans that are positioned to accept electronic claims. For end-to-end electronic claims, payment cycles are reduced from 30 days to 10-14 days, and in some instances as little as five days. In addition, e-claims have resulted in significantly reduced error rates due to the automation of known payer edits.

Educational Support – In response to Revenue Improvement Plan Action Item 4, VA has made revenue training of front-line staff a priority by undertaking numerous education programs to increase awareness of revenue cycle processes. Working with

VA's Employee Education System (EES), the CBO is developing education programs for core revenue business processes including Intake, Registration, Insurance Identification and Verification, Documentation, Billing, AR Management, Coding, Utilization Review (UR), Provider Education, HIPAA/Privacy initiatives, and Health Information Management (HIM). Recognizing that training programs provide a solid educational foundation for VA staff, and foster continued growth and development while supporting VA wide implementation of industry best practices, staff training requirements have also been incorporated into VISN and Medical Center Directors' performance contracts. Training utilities include web-based courses, educational materials, and satellite broadcasts, some of which are detailed as follows:

- HIM initiated a monthly satellite broadcast series in July 1999 in which topics related to coding, billing and documentation are addressed. The broadcasts, which continue to date, consist of presentations delivered by industry experts.

- HIM focused on coder certification and web-based training curriculum, and worked with VA Employee Education System to initiate an internet-based coding curriculum that provides a complete coding training program. VHA currently has over 4,000 employees (coders and non-coders) enrolled in this program.

- A clinician education program was developed to increase awareness among physicians and other clinical staff on the importance of documentation, coding and record maintenance. Further detail on this program is provided in an update to Revenue Improvement Plan Action Item 10, discussed later.

- Web-based courses addressing UR requirements are also under development to facilitate education of clinicians and UR staff on related processes and issues.

- Training programs are being developed to prepare clerical staff to become certified as either a Medical Billing or Accounts Receivable Specialist. It is the intent of the CBO to have all Billing, AR, Coding, and UR staffs participate in certification programs.

Coding Improvement Initiatives – While pursuing longer-term changes in hiring practices and increased salaries to obtain credentialed coders, HIM has proposed centralized coding pools in two VISNs. HIM is also working on streamlining coding efficiency by implementing point of care coding at Outpatient Clinics and developing a Charge Description Master that will eliminate the review and coding of non-billable events. A CDM is also incorporated into the PFSS conceptual solution. These initiatives also contribute to the completion of Revenue Improvement Plan Action Item 13 regarding the development of a Coding Staffing Plan.

Physician Documentation and Record Completion – Some of VA's key challenges in the revenue cycle center around insufficient and/or inconsistent documentation of patient encounters. Inadequate records account for a significant amount of lost revenue. In response to Revenue Improvement Plan Action Items 9 and 11 recommending the use of electronic medical records, VA initially mandated utilization of electronic medical records (CPRS) as well as the use of automated claims analyzer and encoder tools in December 2001. Policy was reissued in May 2003 by the Under Secretary in a memorandum sent to all field stations. VA also developed electronic encounter forms and documentation templates that were released for general use in October 2002. Additional details regarding these efforts are provided in the update to Revenue Improvement Plan Action Item 11, later in this document.

Rates/Charges Publication and Updates – VHA through the CBO is streamlining processes for updating rates charged to insurers consistent with industry market rates for similar services. Reasonable Charges Version 1.4 published in the Federal Register, 4/29/03, updates rates to 2003 levels and adds charges for new diagnostic/procedural codes. Reasonable Charges Version 2.0 is under development and will make a number of changes to the Reasonable Charges rates.

Mid-Term Improvement Strategies: 12-18 months

The following mid-term improvement initiatives are targeted for implementation between July 2003 and December 2004.

Payer Relationship Management Improvements – Recognizing the importance of AR Payment and Denial management (industry journals cite payer relations and denials management competencies as critical to revenue success), the CBO is focused on developing capabilities for improving payer relationships and implementing a formal AR, Payment and Denial Management Program estimated to represent an annualized return of $200M. The program will establish formal Denial Management capabilities at the facility/VISN level and require establishment of audit-appeal business processes and claims development quality controls. The program will leverage technology such as the use of electronic Explanation of Benefits (EOB) forms to manage denials quickly and efficiently. The development of this program also includes the review of all managed care contracts and formal tracking of under payments and late payments. The appeal process and detailed documentation will be available in October 2003 and VISN denial databases will be established by the end of the 2003 calendar year.

Effective October 2003, the CBO in collaboration with VHA's Office of Quality Management is developing policies mandating pre-certification, continued stay review and procedural authorization for all health insured veterans consistent with payer requirements. VA is also establishing standard UR procedures and will have

dedicated "clinical" UR staff at every facility beginning in October 2003. In its first "payer relations test case" the CBO has been working closely with the American Association of Retired Persons (AARP) to identify improvements to billing processes and develop a mutually productive working relationship. Preliminary outcomes have resulted in VA claims being removed from a routine secondary audit process as a result of improved claim quality.

Electronic Medicare Remittance Advice (e-MRA) – Dedicated resources were assigned to support the joint VA/Centers for Medicare and Medicaid Services (CMS) MRA Project in February 2003. While portions of the software have been tested, active development continues with a target completion date of November 2003. The e-MRA project will provide payers with Medicare supplemental claims that identify deductible and coinsurance amounts that Medicare supplemental insurers will use to determine reimbursements to VA for health care services provided to veterans. In addition, VA's ability to reliably identify accounts receivable balances will be greatly enhanced.

Insurance Lockbox – The CBO is developing e-payments business and software solutions (with PNC Bank and WebMD) to electronically receive and process remittance advices from health plans and the associated payments. These electronic transaction processes will provide automated tools to assist field staff in posting payments and standardize adjustment reason codes to assist in Accounts Receivable management. They will also streamline revenue posting and AR closeout through the use of Electronic Remittance Advices and e-payments. While HIPAA does not mandate electronic payments, VA facilities will have the capability to receive them. The target completion date for this project is November 2003.

e-Claims – Action is underway to enhance existing software to auto-process electronic claims for hospital and physician services and address stringent requirements required by certain Blue Cross and/or Blue Shield plans. Electronic transmission of claims will allow for faster payment, reduced GDRO and increased billing productivity. The upgrades will also accommodate the February and March 2003 refinements of the HIPAA Electronic Transactions Final Rule. The target completion date for this project is November 2003.

Software Enhancements – The 2001 Revenue Improvement Plan identified the need to improve the charge capture process (Action Item 19). Related efforts identified that existing VistA clinical applications do not collect episode specific treatment data required for billing purposes. That missing data often results in incorrect, incomplete or rejected bills. A formal study completed in March 2002 estimated that VHA was foregoing $50 million in revenue for inpatient professional fees. VA generates the majority of its revenue from outpatient services which indicates that a substantial increase in revenue, potentially in excess of $100M per

year, could result from the implementation of these clinical application software enhancements.

The CBO has finalized identification of essential data elements in the existing VistA legacy clinical applications and action is being taken to capture (and require input of) that data, which will dramatically improve billing accuracy and collections. Thus, VistA clinical applications will be enhanced to collect and store all relevant data required to bill a product or service, and to recognize these products or services as potential billable events. The near term collection of this data in existing applications will yield immediate revenue improvements and ultimately support the PFSS effort. Necessary system enhancements will be completed for testing by September 2003, and available for VHA-wide release in November 2003.

Centralized Enrollment Information – The VHA Health Eligibility Center is redesigning the HEC database to provide enhanced eligibility and enrollment functionality to improve data quality and sharing of core veteran information. The improved system will also provide the necessary performance, reliability and security for accessing and storing federal tax information. A single VHA enrollment database, targeted for deployment in December 2003, will also provide "register once" capability and consistent/reliable eligibility information across VHA

VHA/VBA Service Connection Information Exchange Improvements – To support accurate enrollment prioritization (and appropriately determine which veterans should be billed or charged co-payments for care) CBO staff working in conjunction with VBA staff are actively pursuing an enhanced VBA/VHA data sharing solution. This initiative is focused on automating current VBA/VHA compensation and award data sharing with an initial focus on expanded access to veterans' service-connected disability ratings information. Action has been taken to improve the availability of service connection (SC) disability information for veterans with more than six SC disabilities (VBA Benefits Delivery Network disability display is limited to six SC conditions). VHA initially identified 81,275 cases known to have greater than six SC disabilities. Matching these cases to the VBA Veterans Information Tracking Adjudication Log (VITAL) database enabled VHA to increase the number of SC disabilities from six to nine. As a result of this effort, VHA display of SC disabilities was enhanced for 66,425 veterans: 20,521 with seven SC disabilities, 14,856 with eight SC disabilities, and 31,048 with nine disabilities displayed (though these cases could have more than 9 SC disabilities).

Electronic Insurance Identification and Verification – It is estimated that an additional $40 million in revenue can be collected for each additional percentage of identified health insurance coverage. In response, VA is developing business and software solutions with WebMD and other health care clearinghouses to automate the identification and verification of health insurance benefits. This e-IIV initiative is targeted for national implementation in November 2003.

Long-Term Improvement Strategies – 18+ months

The following long-term initiatives are targeted for implementation beginning in 2005. Several of these initiatives are already being actively pursued, with milestones established over the next several months.

Patient Financial Service System – The Patient Financial Services System (PFSS) project will result in the implementation of a commercial-off-the-shelf (COTS) health care billing and accounts receivable software system to replace the legacy VistA IB and AR applications. The project will also include the implementation of business process improvements based on commercial best practices, centralization of business processes, and potential outsourcing initiatives. An updated status of PFSS is provided in response to questions 15 –17.

Regional Processing Centers – The CBO is pursuing the establishment of regional service centers throughout VHA to centralize revenue cycle business processes. Included in this effort is the establishment of a National Revenue Call Center that will provide centralized call center services for veterans with questions concerning co-payment bills. The call center will increase revenue by removing the customer service burden from local MCCF staff and allowing them to focus on billing and collection activities. A Benefits Call Center is also being pursued to provide a central call center for veterans' questions about eligibility for health care and other topics.

System Adaptability/Industry Compatible Technology – The CBO in partnership with the Department CIO is focused on ensuring that the integration and or development of new technological improvements are compatible with the VA technology and processing environment. As new systems are implemented, the CBO working with the CIO will ensure integration with the overall VA enterprise architecture.

Organizational Evolution – Working in concert with field-based staff, the CBO is pursuing multiple business process changes to improve revenue and mirror commercial best practices. These process improvements will include VA-wide assignment of responsibility/accountability, more stringent performance measures, incentives, organizational change management and standardization and definition of performance driven expectations.

Coding Staffing Plan – Development of a Staffing Plan for Coding was originally detailed in Revenue Improvement Plan Action Item 13, which recommended development of a comprehensive staffing plan to address known coding deficiencies. The Office of Health Information Management (HIM) completed an extensive study on coding staffing issues within VA and researched coding staffing practices within the private sector. Key findings revealed that 77% of VA sites have coding

vacancies; 41% of VA's existing coders will retire in the next five years; credentialing is not currently required within VA; and that there is a significant difference between the salaries offered in the private sector versus VA. In response, and in addition to the internal training programs discussed above, HIM has formulated a coding staffing plan to address these issues. The plan proposes the Office of Personnel Management modify current requirements to permit direct hiring authority for credentialed coders in order to attract qualified coding staff and calls for the establishment of industry-compatible salaries.

e-Outpatient Pharmacy and e-Dental Claims – Software upgrades are being developed for Outpatient Pharmacy Claims and are planned for Dental Claims. While prescription and dental benefits are minimal, modest additional revenue is expected as a result of these initiatives. Implementation of e-Pharmacy Claims is targeted for completion by April 2004 and the e-Dental Claims Project will be initiated by January 2004.

e-Health Care Services Review and Response – Software upgrades are planned to add new functionality to standardize and automate the health care service review processes. This new functionality will automate the current manual and cumbersome business process and streamline VHA's operations, thereby contributing to increased efficiency and revenue. This project is targeted for initiation by January 2004.

e-Status Messaging – The CBO will upgrade claims status messaging functionality in e-Claims software to attain full HIPAA compliance. This functionality is also expected to improve AR follow-up by quickly identifying "standardized" reasons for denials or suspended claims. This project is targeted for initiation by January 2004.

e-Claims Attachment Pilot – VA is expecting the Final Rule for Claims Attachment this fiscal year. In response to the rule, VHA must develop the capability to electronically receive requests from health plans for additional claim documentation and to respond to the requests electronically. The ability to receive and respond to requests electronically will expedite the claims processing in those situations where payers require additional documentation to determine payment. This project is targeted for initiation by January 2004.

e-Recoupment for Fee Claims Paid – The CBO will upgrade VHA's automated infrastructure to electronically share reimbursable claims data paid through the Fee program to the provider billing system for recoupment. This functionality will significantly improve VHA's ability to identify and bill for Fee Program services paid to community providers, resulting in additional claims and increased collections. This project is targeted for initiation by January 2004.

The information below provides an itemized update and status of the original 24 individual Revenue Improvement Plan Action Items.

1. Mandate pre-registration of veterans – Complete
VHA directive 2002-015 issued March 8, 2002, mandated the use of the pre-registration software by medical centers.

2. Define standards for complete and accurate data capture – Complete
The CBO is in the process of developing a directive to identify required data fields in the VistA software to complement the registration process.

This Action Item is also being pursued through PFSS and VHA CIO Billing Aware initiatives. PFSS teams developing system requirements and process flows are determining data elements required by a billing system. CBO and CIO staffs have identified required data elements and are currently developing VistA enhancements, as detailed in the mid-term improvement strategies section under "Software Enhancements." These system enhancements will serve to immediately improve data capture quality and ultimately support the efficacy of the PFSS solution.

The PFSS initiative includes the design of system and process flows that will ensure more accurate data capture, as well as implementation of standard data collection and capture processes across VA. Additional information on PFSS is provided in the responses to questions 15 – 17 below.

3. Implement Veteran Education Program – Complete
VHA has developed a series of posters, pamphlets and other informational materials for veterans regarding the importance of insurance identification, co-payment requirements and other regulated billing changes. Veteran educational materials were distributed with patient statements released in December 2001, January 2002, and February 2002 and will be reissued on a periodic basis.

4. Implement Employee Education Program – Complete/On going
Employee education programs are being pursued through the Educational Support initiative. Working with VA's Employee Education System (EES), the CBO is developing education programs for core revenue business processes including Intake, Registration, Insurance Identification and Verification, Documentation, Billing, AR Management, Coding, Utilization Review (UR), Provider Education, HIPAA/Privacy initiatives, and Health Information Management (HIM). Recognizing that training programs provide a solid educational foundation for VA staff, and foster continued growth and development while supporting VA wide implementation of industry best practices, staff training requirements have also been incorporated into VISN and Medical Center Directors' performance contracts. Training utilities include web-based courses, educational materials, and satellite broadcasts. This action item is labeled "in process" as it must be perpetually ongoing.

5. Implement electronic insurance identification and verification – On Target

This Action Item is now incorporated in the CBO e-Insurance Identification and Verification (e-IIV) project and is an essential component of the PFSS project. The CBO is also pursuing e-IIV as part of the HIPAA mandated e-Business initiatives. E-IIV is on schedule for national implementation in November 2003. The PFSS conceptual solution includes electronic insurance identification and verification through the use of COTS products. Several VA medical centers are currently using electronic insurance verification tools that are serving as interim solutions while the national solution is developed and implemented.

6. Consolidate insurance information at the enterprise level – On Target.
This Action Item is now being pursued through the PFSS and e-IIV projects. The PFSS conceptual solution includes an enterprise Insurance Master File. The e-IIV project is scheduled for release in November 2003. The consolidation of insurance information across the entire VA will occur in FY 2005.

7. Develop an Employer Master File – Cancelled
After analysis, the field-based workgroup assigned to this action item determined an Employer Master File database would not be cost effective. The team instead recommended that collection of veterans' employer and insurance data become a mandatory element of all patient registrations. Implementation of this recommendation would provide all of the benefits of an Employer Master File without the development expense. See item 2 above.

The PFSS conceptual solution provides more comprehensive pre-registration processes including collection and verification of veterans' employer and insurance data during the patient intake process.

8. Enforce national documentation policy –On Going
The Health Information Management and Health Records handbook is in the last stages of concurrence. On July 17, 2003, final edits were received from General Counsel. All edits will be incorporated into the final document. An exact date for publishing has not yet been set.

9. Mandate use of electronic medical records (CPRS) –On Going
In January 2002 the Under Secretary for Health mandated full implementation of CPRS, with performance measures, by 2004.

10. Develop national clinical education program –On Going

Representatives from Health Information Management worked with EES to develop and distribute a comprehensive clinical education toolkit. The initiative included: posters and laminated pocket reference cards with CPT codes and CPT evaluation and management service selection guidelines, videos, presentations for use at clinical staff meetings and quick reference guides. Materials have also been posted on the VA Physician Education website. A commercial web based training program was selected by the Health Information Management Program and purchased by the Employee Education System. There are currently over 4,000 VHA staff enrolled in this training.

11. Develop and mandate use of electronic encounter form and documentation templates – Complete

Electronic encounter forms were developed and released for Mental Health, Primary Care, Gastroenterology, Urology, Pulmonary, Podiatry, Eye, Cardiology (2 forms), General Surgery, Orthopedics, Hematology/Oncology, Physical Medicine and Rehabilitation, and Dermatology.

Primary Care and Mental Health templates were posted to the HIM web site in October 2002. In addition standardized documentation templates for eye care, surgical care, attending notes, acute/and extended care and history and physical have also been posted. Development of additional encounter forms is ongoing and national utilization of the forms was mandated in VHA directive 2003-012 effective nationally October 1, 2003.

12. Develop and implement documentation tracking system – On Target

This solution is embedded in a number of projects including Billing Aware and CPRS Re-engineering. Claims Analyzers provide coders and billers immediate access to claims requiring edit reviews. An initiative to develop an easier method for clinicians to appropriately associate current treatment to service-connected conditions and ensure that encounters are being appropriately billed is under development. The initiative to develop centralized coder pools includes a strategy for exploring the use of emerging software utilities to track and improve workflow. Additional vendor software enhancements that will facilitate the identification of billable encounters and reduce billing production time are also being explored. With regard to Document Tracking---This item has been embedded in a number of current projects, including Billing Aware software functionality upgrades to make the clinical packages more billing aware and CPRS Re-engineering. CPRS re-engineering will include many additional reporting features that will notify clinicians of missing or needed documentation. There are initiatives in discussion to provide clinicians with electronic functionality that to assist with note writing, coding, and functionality that will improve workflow of coders. Other vendor software enhancements already available assist

with improving the process to identify billable encounters and claims that require manual review prior to billing, therefore reducing time to bill.

13. Develop staffing plan for coding resource – Complete
Health Information Management submitted an initial proposal in October 2002. A separate document was released to the field communicating coding standards as a result of this project. Recommendations relative to recruitment and retention issues are being pursued at this time. While the actual development of the Staffing Plan is complete, it is important to note that actual implementation of the plan and pursuit of its goals are still being pursued.

14. Mandate use of encoder software – Complete
The ADUSH issued a memo to Network Directors requiring the use of encoder software in December 2001. All sites now have encoder software installed. Use of electronic claims analyzers was endorsed in a network memorandum to the field in May 2002. Currently most medical centers are using electronic claims analyzers and encoder tools in coding and billing processes. However, in the same memo discussed in items 9 and 11, the Under Secretary for Health mandated utilization of encoders and claims scrubbers at all facilities.

15. Develop national standard for laboratory, radiology, and other ancillary test names and corresponding CPT codes – On Target
CBO and VHA CIO representatives identified clinical application deficiencies and issues related to lack of standardization and corresponding CPT codes. This Action Item is being resolved through the implementation of PFSS, as it will incorporate use of standard CPT codes. COTS billing products are equipped with standard AMA CPT codes, and COTS vendors automatically release code updates for their products as soon as they are available from AMA.

16. Mandate minimum access policy to VistA ancillary packages – Complete
Previously, coders and billers lacked access to many of the clinical ancillary applications in which potential billable episodes are captured. As a result, numerous billable episodes were unidentified, resulting in lost revenue. Providing billing staff with access to VistA clinical applications would increase identification of billable events and claims accuracy. Therefore, a memorandum was issued to the field mandating minimum access policy to VistA ancillary packages in May 2002.

17. Complete implementation of the EDI Billing and MRA projects – On Target
This Action Item is being pursued through the CBO's e-MRA, e-Payments (third-party lockbox) and e-Rx claims projects detailed below:

e-Claims – Initial e-Claims software is operational at all VA facilities, and over four million electronic claims have been generated as of April 2003. This software has reduced payment receipt times from those health plans that are positioned to accept

electronic claims. For end-to-end electronic claims, payment cycles are reduced from 30 days to 10-14 days, and in some instances as little as five days. In addition, e-claims have resulted in significantly reduced error rates due to the automation of known payer edits. Action is underway to enhance existing software to auto-process electronic claims for hospital and physician services and address stringent requirements required by certain Blue Cross and/or Blue Shield plans. Electronic transmission of claims will allow for faster payment, reduced GDRO and increased billing productivity. The upgrades will also accommodate the February and March 2003 refinements of the HIPAA Electronic Transactions Final Rule. The target completion date for this project is November 2003.

Electronic Medicare Remittance Advice (e-MRA) – Dedicated resources were assigned to support the joint VA/Centers for Medicare and Medicaid Services (CMS) MRA Project in February 2003. While portions of the software have been tested, active development continues with a target completion date of November 2003. The e-MRA project will provide payers with Medicare supplemental claims that identify deductible and coinsurance amounts that Medicare supplemental insurers will use to determine reimbursements to VA for health care services provided to veterans. In addition, VA's ability to reliably identify accounts receivable balances will be greatly enhanced.

Insurance Lockbox – The CBO is developing e-payments business and software solutions (with PNC Bank and WebMD) to electronically receive and process remittance advices from health plans and the associated payments. These electronic transaction processes will provide automated tools to assist field staff in posting payments and standardize adjustment reason codes to assist in Accounts Receivable management. They will also streamline revenue posting and AR closeout through the use of Electronic Remittance Advices and e-payments. While HIPAA does not mandate electronic payments, VA facilities will have the capability to receive them. The target completion date for this project is November 2003.

18. Implement "claims analyzer" tools - Complete

The ADUSH issued a memo to Network Directors mandating used of claims scrubber software in December 2001. In May 2002, VHA leadership encouraged use of specific tools and VA's agreement to support interfaces in May 2002. In May 2002, an Ingenix software interface was released to the field. Several VISNs have implemented and are using either the Quadramed or Ingenix software. Again, in his memo released in April 2003, the Under Secretary has reaffirmed this as a mandated process requirement.

19. Improve the charge capture process – On Target

This Action Item is now being pursued through the Billing Aware (Software Enhancements) and PFSS projects identified in the Mid-Term and Long-Term Improvement Strategies. The VHA CIO Billing Aware teams completed Systems

Requirements Specifications for eight VistA clinical applications and are in the process of implementing required improvements. The enhanced applications will be implemented across the VA by November 2003.

20. Consolidate/outsource VHA "3rd Party" Accounts Receivable follow-up – Complete/On Going

This Action Item is now being pursued through the "Accounts Receivable Follow-Up" and "Expanded Contract Support" initiatives detailed in the Immediate Improvement Strategies section.

21. Develop utilization review (UR) program –On Target

A new UR policy calling for assessment of dedicated clinical professionals to UR is in concurrence and once approved will become formal policy. The Utilization Review team is now working with VA Employee Education System to finalize four web-based modules to provide training materials for Utilization Review staff.

22. Request VA General Counsel more aggressively pursue "referred" 3rd party Accounts Receivable –On going

A formal request for General Counsel support of accounts receivable follow up was initially submitted in May 2002. Since then, CBO and OGC have established an ongoing dialogue and working group to address revenue issues. As a result, CBO and OGC have initiated several improvements, including development of revised reasons for referral, software changes to the electronic referral system between the MCCF staff and Regional Counsel offices; a denials code management program; and a strategy to address aging receivables.

23. Implement insurance payment and remittance program – On Target

This Action Item is being pursued through the CBO's EDI Lockbox (e-Payments project) detailed in the mid-term improvement strategies section, under "EDI Lockbox". The EDI Lockbox System currently being developed will enable the electronic transmission of insurance payments and remittance advices to VHA through a contracted commercial financial institution for payment processing. Lockbox software is currently in development. Software integration and user acceptance testing started in January 2003. Training materials are being refined. E-Payments is currently on schedule for a November 2003 implementation.

24. Implement Accounts Receivable management software – On Target

This Action Item is being pursued through the PFSS project. PFSS will provide COTS AR management functionality that incorporates private sector best practices for the processing and management of Accounts Receivable. This functionality will be installed in the VA Health Care Network of Ohio (VISN 10) by September 2004.

Attachment B – Response to Buyer Question 14

VHA Rank of Facilities By Percent of Collections to Goals Using Medicare Unadjusted Data for June 2003

Sta No	Facility Name	Jun-03
593	Las Vegas	127%
618	Minneapolis	125%
561	New Jersey HCS	124%
459	Honolulu	120%
666	Sheridan	119%
668	Spokane	119%
600	Long Beach	117%
605	Loma Linda	117%
619	CAVHCS(Montgomery)	117%
538	Chillocothe	116%
589	Kansas City, MO	114%
557	Dublin	112%
552	Dayton	111%
575	Grand Junction	111%
654	Sierra Nevada HCS	110%
437	Fargo	109%
539	Cincinnatti	109%
623	Muskogee	108%
436	Fort Harrison	108%
516	Bay Pines	107%
438	Sioux Falls	107%
664	San Diego	106%
667	Shreveport	106%
544	Columbia	106%
612	No. CA HCS	106%
656	St. Cloud	106%
636	Nebraska/W. Iowa	106%
598	Little Rock	106%
660	Salt Lake City	106%
640	Palo Alto HCS	106%
757	Columbus	105%
662	San Francisco VAMC	105%
534	Charleston	105%
657	St. Louis, MO	105%
549	N Texas VAHCS	104%
541	Cleveland	104%
402	Togus	103%
564	Fayetteville AR	103%

VHA Rank of Facilities By Percent of Collections to Goals Using Medicare Adjusted Data for June 2003

Sta No	Facility Name	Jun-03
618	Minneapolis	117%
593	Las Vegas	116%
561	New Jersey HCS	114%
600	Long Beach	113%
666	Sheridan	106%
619	CAVHCS(Montgomery)	106%
668	Spokane	105%
623	Muskogee	105%
589	Kansas City, MO	104%
459	Honolulu	103%
605	Loma Linda	103%
552	Dayton	103%
557	Dublin	102%
437	Fargo	102%
438	Sioux Falls	101%
654	Sierra Nevada HCS	101%
636	Nebraska/W. Iowa	100%
564	Fayetteville AR	100%
667	Shreveport	99%
436	Fort Harrison	99%
516	Bay Pines	99%
575	Grand Junction	99%
662	San Francisco VAMC	98%
549	N Texas VAHCS	98%
581	Huntington	98%
657	St. Louis, MO	97%
660	Salt Lake City	97%
539	Cincinnatti	97%
640	Palo Alto HCS	97%
402	Togus	96%
612	No. CA HCS	96%
534	Charleston	96%
656	St. Cloud	96%
580	Houston	95%
538	Chillocothe	95%
649	N. Arizona VAHCS	95%
544	Columbia	95%
607	Madison	94%

581	Huntington	103%
570	Central CA HCS	101%
621	Mt. Home	101%
608	Manchester	101%
695	Milwaukee	101%
405	White River Jct.	101%
649	N. Arizona VAHCS	100%
518	Bedford	100%
540	Clarksburg	100%
650	Providence	100%
632	Northport	100%
585	Iron Mt	99%
603	Louisville	99%
689	Conn HCS	99%
679	Tuscaloosa	99%
586	Jackson	99%
523	Boston	99%
568	Black Hills	98%
676	Tomah	98%
613	Martinsburg	98%
607	Madison	98%
521	Birmingham	97%
692	So. Oregon Rehab	97%
578	Hines	97%
614	Memphis	97%
520	Biloxi	97%
531	Boise	96%
691	Greater Los Angeles	95%
580	Houston	95%
583	Indianapolis	95%
631	Northampton	95%
529	Butler	95%
517	Beckley	94%
556	N Chicago	94%
548	West Palm Beach	94%
503	Altoona	94%
596	Lexington	94%
535	Chicago	93%
620	Hudson Valley HCS	93%
655	Saginaw	92%
626	TN Valley	92%
558	Durham	92%
659	Salisbury	91%
637	Asheville	91%
565	Fayetteville	91%

405	White River Jct.	94%
757	Columbus	93%
621	Mt. Home	93%
521	Birmingham	92%
518	Bedford	92%
517	Beckley	92%
586	Jackson	92%
650	Providence	92%
664	San Diego	91%
568	Black Hills	90%
608	Louisville	90%
695	Milwaukee	90%
523	Boston	90%
558	Durham	90%
676	Tomah	90%
570	Central CA HCS	89%
689	Conn HCS	89%
659	Salisbury	89%
541	Cleveland	89%
679	Tuscaloosa	89%
503	Altoona	89%
585	Iron Mt	89%
583	Indianapolis	88%
565	Fayetteville	88%
608	Manchester	88%
520	Biloxi	87%
596	Lexington	87%
531	Boise	87%
578	Hines	87%
548	West Palm Beach	87%
556	N Chicago	86%
562	Erie	85%
693	Wilkes-Barre	85%
529	Butler	84%
620	Hudson Valley HCS	84%
554	Denver	84%
540	Clarksburg	84%
691	Greater Los Angeles	84%
632	Northport	83%
610	North. Indiana HCS	83%
595	Lebanon	83%
508	Atlanta	82%
653	Roseburg	82%
631	Northampton	82%
626	TN Valley	81%

610	North. Indiana HCS	91%
693	Wilkes-Barre	91%
595	Lebanon	91%
562	Erie	90%
554	Denver	90%
526	Bronx	90%
508	Atlanta	90%
460	Wilmington	89%
509	Augusta	89%
653	Roseburg	89%
550	Danville	89%
644	Phoenix VAMC	88%
673	Tampa	88%
442	Cheyenne	88%
573	North Fl/South Ga	86%
635	Oklahoma City	85%
515	Battle Creek	85%
506	Ann Arbor	85%
642	Philadelphia	85%
674	C Texas VAHCS	84%
652	Richmond	84%
646	Pittsburgh	83%
504	Amarillo VAHCS	83%
756	El Paso VAHCS	83%
502	Alexandria	83%
519	W. Texas VAHCS	83%
553	Detroit	81%
648	Portland	81%
546	Miami	81%
678	S. Arizona VAHCS	79%
542	Coatesville	79%
663	Puget Sound HCS	79%
501	New Mexico VAHCS	78%
590	Hampton	76%
528	Buffalo	75%
672	San Juan	75%
512	Baltimore	74%
671	S Texas VAHCS	71%
688	Washington DC	71%
687	Walla Walla	70%
630	NY Harbor HCS	69%
658	Salem	68%
629	New Orleans	61%
463	Anchorage	60%

652	Richmond	81%
673	Tampa	80%
573	North Fl/South Ga	79%
535	Chicago	79%
635	Oklahoma City	79%
642	Philadelphia	78%
460	Wilmington	78%
550	Danville	78%
655	Saginaw	78%
526	Bronx	78%
613	Martinsburg	77%
646	Pittsburgh	77%
644	Phoenix VAMC	77%
648	Portland	77%
502	Alexandria	76%
674	C Texas VAHCS	76%
756	El Paso VAHCS	75%
504	Amarillo VAHCS	75%
515	Battle Creek	74%
546	Miami	74%
501	New Mexico VAHCS	73%
678	S. Arizona VAHCS	73%
509	Augusta	72%
553	Detroit	71%
519	W. Texas VAHCS	71%
442	Cheyenne	71%
542	Coatesville	71%
528	Buffalo	70%
590	Hampton	70%
506	Ann Arbor	70%
663	Puget Sound HCS	69%
658	Salem	65%
688	Washington DC	63%
692	So. Oregon Rehab	63%
671	S Texas VAHCS	62%
687	Walla Walla	62%
512	Baltimore	58%
637	Asheville	58%
463	Anchorage	56%
672	San Juan	55%
629	New Orleans	49%
630	NY Harbor HCS	48%
614	Memphis	*
598	Little Rock	*

* No Obligation Data found for these sites.

Attachment C – Response to Buyer Question 28

Refer at 60 Days - Station has an Accounts Receivable and Refers Accounts when They are 60 Days Old from Date of Bill

VISN	FACILITY NAME
1	TOGUS
1	WHITE RIVER JCT
1	BEDFORD
1	MANCHESTER
1	NORTHAMPTON
2	ALBANY
2	BATH
2	BUFFALO (Int)
2	SYRACUSE
4	WILMINGTON
4	ALTOONA
4	BUTLER
4	CLARKSBURG
4	COATESVILLE
4	ERIE
4	LEBANON
4	PHILADELPHIA
4	PITTSBURGH (Int)
4	WILKES-BARRE
5	BALTIMORE (Int)
5	MARTINSBURG
5	WASHINGTON
7	ATLANTA
7	AUGUSTA
7	COLUMBIA (SC)
7	DUBLIN
7	MONTGOMERY (Int)
7	TUSCALOOSA
8	BAY PINES
8	MIAMI
8	WEST PALM BEACH
8	GAINESVILLE
8	SAN JUAN
8	TAMPA
9	HUNTINGTON

VISN	FACILITY NAME
9	LEXINGTON
9	LOUISVILLE
9	MEMPHIS
9	MOUNTAIN HOME
9	NASHVILLE (Int)
10	CLEVELAND
16	ALEXANDRIA
16	BILOXI
16	HOUSTON
16	JACKSON
16	MUSKOGEE
16	NEW ORLEANS
16	OKLAHOMA CITY
16	SHREVEPORT
18	ALBUQUERQUE
18	AMARILLO
18	BIG SPRING
18	PHOENIX
18	PRESCOTT
18	TUCSON
18	EL PASO OPC
20	SEATTLE (Int)
22	LAS VEGAS
22	LONG BEACH
22	SAN DIEGO
22	WEST LOS ANGELES(Int)

Attachment C – Response to Buyer Question 28

No Contracts- Station Does Not Use an Accounts Receivable Vendor

VISN	FACILITY
1	BOSTON (Int)
1	PROVIDENCE
1	WEST HAVEN (Int)
10	CHILLICOTHE
10	DAYTON
10	COLUMBUS OPC
16	FAYETTEVILLE (AR)
16	LITTLE ROCK
19	FORT HARRISON(Int.)
19	CHEYENNE
19	DENVER
19	FORT LYON
19	GRAND JUNCTION
19	SALT LAKE CITY
19	SHERIDAN
20	ANCHORAGE
20	BOISE
20	PORTLAND
20	ROSEBURG
20	SPOKANE
20	WALLA WALLA
20	WHITE CITY DOM

Attachment C – Response to Buyer Question 28

Refer at 60 or More Days -
Facility has an Accounts Receivable Vendor and Refers Accounts at More Than 60 Days from Date of Bill

VISN	Facility
3	BRONX
3	EAST ORANGE (Int)
3	MONTROSE (Int)
3	NEW YORK (Int)
3	NORTHPORT
6	BECKLEY
6	DURHAM
6	FAYETTEVILLE (NC)
6	HAMPTON
6	ASHEVILLE
6	RICHMOND
6	SALEM
6	SALISBURY
7	BIRMINGHAM
7	CHARLESTON
10	CINCINNATI
11	ANN ARBOR
11	BATTLE CREEK
11	DANVILLE
11	ALLEN PARK
11	INDIANAPOLIS
11	MARION (IN) (Int)
11	SAGINAW
12	CHICAGO (Int)
12	NORTH CHICAGO
12	HINES
12	IRON MOUNTAIN
12	MADISON
12	TOMAH
12	MILWAUKEE
15	WICHITA
15	COLUMBIA (MO)
15	KANSAS CITY
15	MARION (IL)
15	POPLAR BLUFF
15	ST LOUIS
15	TOPEKA (Int)
17	DALLAS (Int)
17	SAN ANTONIO (Int)
17	TEMPLE (Int)